STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	02/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BERKSHIRE OF CASTLETON	8480 CRAIG ST INDIANAPOLIS, IN 46250

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R0000	This visit was for the Investigation of Complaint IN00118853. Complaint IN00118853-Substantiated. State deficiencies related to allegations are cited at R247. Survey date: February 6, 2013 Facility number : 009894 Provider number : 009894 AIM number: N/A Survey team: Michelle Hosteter RN Census bed type : Residential : 123 Total : 123 Census payor type: Other: 123 Total : 123 Sample : 6 These state findings are cited in accordance with 410 IAC 16.2. Quality Review completed on 2/13/13, by Tammy Alley RN.	R0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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R0247	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency (7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident. Based on record review and interview, the facility failed to have documentation of a medication error and to notify the physician of the medication error for 2 of 6 residents reviewed for medication errors in a sample of 6. (Resident B and Resident D) Findings include: 1. The record review for Resident B was completed on 2/6/13 at 11 A.M. Diagnoses included, but were not limited to, atrial fibrillation, congestive heart failure and diabetes. A physician's order dated 10/18/12, indicated "... Coumadin 1 mg [milligram] p.o. [by mouth] for two days and then stop on 10/20/12 and resume normal dose...." The MAR (Medication Administration Record) for October did not indicate any order on 10/18/12 and 10/19/12 for Coumadin 1 mg. The normal dose	R0247	**R000 Initial comments:** **The following is the Plan of Correction for Berkshire of Castleton in regards to the Statement of Deficiencies for the complaint surveys completed on 2-6-13 This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvement to satisfy that objective.** **R 247 Health Services (deficiency)** ***What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?*** · Resident B: The Health and Wellness Director / Executive Director met with the third-party provider in order to go over a more appropriate documentation process for their nurses to follow when receiving new physician	03/04/2013

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	of Coumadin 2 mg to be given on Mondays, Tuesdays, Wednesdays, Thursdays, Fridays and Saturdays was marked in the boxes on the 18th and 19th with what looked like initials in them, signifying the medication was given. The 18th had a box written in underneath the initials and an arrow with no initials in it. The back of the MAR had no documentation of any doses being held. The nurses notes did not reflect any changes in orders or that a medication had been held. In an interview with the Health and Wellness Director (HWD) on 2/6/13 at 11:35 A.M., she indicated the Coumadin was not changed on 10/18/12 as the physician had ordered. She indicated the nurses did not transcribe and follow the order as written and indicated that would be a medication error. The information provided by the Health and Wellness Director (HWD) on 2/6/13 at 1:30 P.M., indicated LPN #2 and LPN #3 had both not followed physician's orders regarding the Coumadin order on 10/18/13. She indicated she was unaware this error had occurred. 2. The record review for Resident D		orders, lab results., and how these are to be documented and communicated with our community's nurses. The alleged error was documented, with physician and responsible party notifications completed. There was no adverse effect noted to the health and well-being of the resident. All PT/INR requests and communication with physician regarding results is now being completed by nursing staff. · Resident D: The alleged deficient practice was reported to the physician and the responsible party following existing policy. The resident is currently stable. ***How will the facility identify other residents with the potential to be affected by the same alleged deficient practice and what corrective action will be taken?*** · Other residents who have a third party provider involved in obtaining physician orders, as well as residents who have issues with medication availability may have the potential to be affected by the alleged deficient practice · Nursing staff was re-educated on the existing "Med Administration: Med Availability, the Med Administration: Medication Error Reporting, as well as the INR Tracking Form Policies and Procedures. This re-education was provided by the Health and Wellness Director (LPN)/designee. · A Medication Administration audit was completed for all residents who receive medication administration services, for the previous 30 days, in order to determine other residents who may have been affected by missed medications due to meds not available. · A PT/INR tracking form is currently in use for residents who receive Coumadin administration services from our nursing staff, in order	

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	was completed on 2/6/13 at 1 P.M. Diagnoses included, but were not limited to, bipolar, hypothyroidism, and insulin dependent diabetes mellitus. The MAR indicated during October the resident was to receive Lorazepam 0.5 mg by mouth daily at bedtime. The dates all had initials in the boxes except the 16th, and 10/5/12 and 10/6/12 the initials were circled. The back of the MAR had no documentation of any doses being held or missed. The nurses notes did not indicate any information regarding Lorazepam 0.5 mg not being given on 10/5/12 or 10/6/12. The nurse's notes for 10/7/12 at 12:30 A.M., indicated, "... the resident was complaining of feeling jittery, had some sporatic [sic] twitches in arms, gave Tramadol; checked back later [sign for and] she said she was feeling better." The 4:00 A.M., entry indicated Resident D complained of feeling like she might have a seizure and asked to have her daughter called.		to comply with lab dates and new orders from physicians. The Health and Wellness Director/Nurse Designees have audited these records to determine compliance for other residents who may have the potential to be affected. **What measures will be put in place or what systemic changes will the facility make to ensure the alleged deficient practice does not recur?** · Per the community's existing "Medication Administration policies and procedures", the community will continue to be responsible for obtaining newly ordered medication or refills for medications and treatment orders, unless otherwise agreed upon with the resident, family, or legally responsible party in accordance with the Pharmacy Services Agreement Addendum to our existing Residency Agreement. · In the event the resident or legally responsible party have signed the Pharmacy Services Agreement stating that they will have the responsibility for obtaining newly ordered medication or re-ordering medications, but the medications are not delivered within two days prior to the depletion of the medication stock, the community will order or re-order the medications with the community's "preferred provider" to insure no disruption takes place. · The family will be responsible to pay for the medications and any associated service charges. The fees associated with re-ordering medications from the preferred pharmacy are determined by the preferred pharmacy and are in addition to the community's service fee. · When a medication is unavailable for any reason, the nurse is	

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	The 9:50 A.M., entry indicated "...Physician was notified about receiving a script or phone order for Lorazepam 0.5 mg. The physician said she would call in order today so could have it by Monday's order. The pharmacy was contacted to let them know status of medication..." The 1:40 P.M., entry indicated the nurse called the pharmacy to check the status of the medication and it was on schedule to be delivered on the next delivery date. The documentation at this time did not indicate the physician was notified the resident did not receive medication on 10/5/12 and 10/6/12. The information provided by the HWD regarding medication errors on 2/6/13 at 10:10 A.M., indicated that LPN #1 had a medication error on 10/25/12. She also provided disciplinary action documentation on LPN #1 dated 10/25/12, that described the incident as "...failure to obtain a prescribed medication that was unavailable for a resident on 10/6/12...." During an interview with the HWD on 2/6/13 at 2 P.M., she indicated the medication error information on LPN #1, was related to Lorazepam.		to notify the resident and/or responsible party as well as the physician. The MAR is to be initialed with a circle to indicate the medication was not given, and, on the back of the MAR, the nurse is to indicate the reason for the missed medication. The incident is to be documented in the clinical record, as well as all attempts to obtain the medication in a timely manner. Missed/circled medications are to be considered a medication error and the appropriate documentation will be required. · Regarding PT/INR and subsequent Coumadin orders: Third party providers have been advised to write orders in the clinical record for any new dosage changes and or follow-up labs that are part of the resident's service plan in order to properly communicate changes in orders to the nurses who are providing resident care. **How will the corrective actions be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place?** · The Medication Nurse will complete a MAR audit at the end of each shift. This includes auditing for compliance with the PT / INR Tracking form. All discrepancies are to be reported to the Health and Wellness Director/Nurse Supervisor on duty. · Based on the results of the investigation, the community may take such action as it deems appropriate with respect to the employment or contract status of the nurses who commit medication errors or who do not properly document new orders or order changes in the clinical record, up to and including termination of employment or the third-party contract.	

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			By what date will these systemic changes be implemented? · 3-4-13	